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CLINICAL LECTURES AND REPORTS.

PHILADELPHIA HOSPITAL.

CLINIC OF JEFFERSON MEDICAL COLLEGE.

November 16, 1844.

BY PROFESSOR DUNGLISON.

(Reported by Mr. Samuel G. White.)

Professor Dunglison repeated his remark, made at the conclusion of the last clinical lecture, that he should endeavour to present to the class, for clinical observation, such cases as would tend to elucidate the various points to which their attention had been directed, during the week, from the chair of Institutes in the College.

In the present instance, however, he deemed it advisable to deviate somewhat from this plan, by commencing the lecture with some remarks on a well marked case of the affection recently distinguished as

TYPHOID FEVER,

of the existence of which, in the wards, he was not aware until his arrival this morning at the Hospital.

The chain of morbid phenomena constituting this disease, it is well known, many have referred to a peculiar intestinal lesion, in which the mucous follicles—glands of Peyer—near the termination of the small intestines, form a prominent feature.

The lecturer, from his own observations, and a careful examination of the recorded observations of others, is not disposed to coincide in opinion with those who consider typhoid fever to be merely symptomatic of this lesion, and a separate and distinct disease from typhus; but he is rather induced to believe that they, with the black-tongue fever, are different varieties of adynamic fever.

As to the true nature of the disease, various opinions are entertained by different observers. Some, with Bretonneau, consider the essence of the affection to consist in the intestinal lesion, and hence the term dothineritis applied to it. Others view the lesion, with the *taches rouges*, in the same light with the eruption of variola, morbilli, scarlatina, &c., as merely expressions of the disease, and not absolutely necessary to its existence.

From extensive observations made in England, and elsewhere, both in public and private practice, it would seem to be probable that different phenomena may occur as expressions of the same adynamic fever; that the same symptoms may be present with the intestinal lesion, constituting typhoid, or without it as in typhus, and the nature of the affection may only be determined, in many instances at least, by a *post mortem* examination. How are we, then, to determine, when summoned to a patient, which affection is present? Is the judgment in those cases to be suspended until a necroscopical investigation reveals the only feature of distinction, the intestinal lesion? This must certainly be requisite in

some instances, for the two diseases often so closely resemble each other as to be distinguishable in no other manner.

According to the severity of symptoms, adynamic fever was divided by the older writers into typhus gravior, and typhus mitior—the former corresponding with the typhus of modern writers; while the latter included the typhoid fever as described by certain recent authors.

Typhus, admitting the modern distinctions, is a disease very prevalent in England, whilst it is extremely rare both in Paris and this country; but the reverse is true in respect to typhoid fever. To this circumstance may be attributed the discrepancies in the description of continued fever, which exist among English and French writers—the former contending that the intestinal lesion is seldom,—the latter that it is always, present; the English considering it accidental, whilst many of the French believe it to be the pathological character of their fever,—both accurately describing the febrile variety, which they are accustomed respectively to meet with.

Some admit only this distinction in continued fever, that where there is no intestinal disease, it is typhus; where there is, it is typhoid; but the bent of the lecturer's observations is towards the belief, that both are different expressions of adynamic fever, for in the same epidemic identical vital phenomena may be present in cases with and without the intestinal lesion.

As usually described, the vital manifestations of typhoid fever are well marked—there is headache, or tension across the forehead—epistaxis, confusion of intellect, peculiar expression of countenance, somnolency, more or less delirium and stupor, diarrhoea, meteorism, gurgling, with pain on pressure in the right iliac fossa, &c. About the close of the first week, a peculiar eruption, the *taches rouges*, may be discovered by careful examination in the majority of cases.

It commonly appears, first about the chest and abdomen, in the form of rose colored lenticular spots, slightly elevated above the surface, which are almost entirely dissipated by passing the finger over them; the redness immediately returning after the finger has been removed.

[These *taches rouges* were exhibited by the Professor to the class, on the patient before him, and were distinctly seen.]

Besides these, which are considered peculiar to typhoid fever,—at a later period may be seen a number of minute vesicles—sudamina—scattered over the abdomen and other parts of the surface. They are not peculiar to the disease, though it is stated they occur more frequently in it than any other, but seem to be closely connected with the cutaneous exhalation; in fact they bear some ratio to the amount of perspiration, and are most abundant in those parts where the sweat naturally collects, as the axilla, inguinal region, &c. The expression of countenance in typhoid is very peculiar, so much so as to be easily recognized after it has once been seen. In the present instance the patient—a female—was ad-

mitted for ordinary fever, but in passing the wards immediately before lecture, the lecturer was struck with her appearance, and examination proved it to be a case of this disease.

The patient now under consideration exhibits several of the phenomena, just alluded to, in a very marked degree. The peculiar expression of countenance, mentioned as so characteristic, is very obvious. The *taches rouges* are unusually numerous, the chest and abdomen being very thickly studded with them. Pressure on the right iliac fossa elicits the gurgling, but produces no pain. There is some diarrhoea, and there has been epistaxis, with headache and giddiness. No sudamina are as yet perceptible, although they may occur at a later period. Inasmuch as they are so generally present, there seems no impropriety in considering the *taches rouges* to be as much a characteristic expression of typhoid fever, as the ulceration of the intestinal follicles. In the present case, there is not much, if any, development of the spleen, which may often be felt below the margin of the ribs.

The treatment of fever in general has very much changed in recent periods. Formerly, it was customary to bleed freely and purge violently in every case, but that system has been generally replaced by one more philosophical, suggested by "rational therapeutics." It is now very simple. Instead of giving enormous doses of calomel and jalap, and other cathartics, which would call the patient frequently out of bed—ten or twelve times in the twenty-four hours—and thus counteract any good that might arise from quietude in other respects, we adopt a very different course. Violent purgatives, by augmenting the peristaltic action of the intestines to an inordinate degree, cannot but increase any existing irritation of the digestive apparatus. We now know, that the most soothing measures are the most fraught with benefit in all febrile disturbances, and *a fortiori* in typhoid fever, where there is ulceration of the intestinal follicles. The mildest means are, therefore, adopted—the bowels are kept open and the morbid secretions removed by gentle cathartics, as castor oil, or by enemata; the tongue, which is usually dry and cracked, is moistened by the use of iced water, and the surface kept in a temperate condition by cool applications, such as sponging with cold water, &c.

Later in the disease, when the strength begins to fail, gentle excitants, as tonics, may be administered, but caution is required to avoid over-stimulation, which could not fail to be injurious.

As these fevers cannot be cut short, the main care of the physician should be to rectify deranging circumstances and to support the system until the malignant influence has passed away. Occasionally, benefit may be derived from making counter-irritation over the iliac fossa, or by covering the same region with poultices or emollient applications. The disease has a natural tendency to run a fixed course, a circumstance which should not be lost sight of in the treatment. By adopting the mode of management indicated above, we may succeed in conducting cases to a favorable termination, when by more violent plans a fatal issue might have been the consequence.

DISEASES OF IMBIBITION.

The Professor then proceeded to make a few observations on several pathological cases illustrative of the property of penetrability possessed by animal membrane, a subject, which had occupied the consideration for the class, during several days past, at the Jefferson Medical College. It was not his intention to describe them, as particular diseases, in detail,

inasmuch as they would be subjects for future remarks, but merely to point out several facts of interest connected with the phenomenon just alluded to.

PULMONARY TRANSUDATION—HÆMOPTYSIS.

The first case—one of frequent occurrence—presented several points of interest to the physician. It was that of a female—Hannah S., æt. 60—who was admitted into the Hospital on the 20th ult., for a cough of some duration, accompanied by hæmoptysis. The quantity of blood expectorated gradually increased after her entrance, although at times it yielded to the remedies employed, and a few nights since was very abundant. This was succeeded, in a few days, by copious expectoration of a bloody puriform matter, which subsequently became somewhat nummular, and at present consists almost entirely of muco-purulent matters. On examining the chest, a few days ago, the Professor detected consolidation near the summit of the left lung—one of the usual points in which tubercular deposits take place, and signs of a cavity in the inter-scapular region, near the base of the lung. The presence of this cavity was evinced by cavernous respiration, mucous rhonchi and pectoriloquy. In conjunction with these physical signs, the patient has the common vital manifestations of phthisis, as heat of surface, burning of the soles of the feet, night sweats, &c.

[The Professor here exhibited to the class the expectoration of the patient, which had been collected for several days. Some portions of it contained large quantities of blood, while others consisted almost wholly of puriform matter.]

By considering the anatomical constituents of the lung and their several relations, it can readily be understood that hæmoptysis may result in two modes,—from simple transudation through the coats of the vessels, or from ulceration and consequent hemorrhage. Thus, if tubercular matter be deposited in any portion of the lung so as to produce a mechanical impediment to the circulation, it can be easily comprehended that transudation or soaking out of the blood through the coats of the vessels may result, and that this will be much facilitated by an impoverished condition of that fluid, conjoined with softening of the pulmonary structures, as occurs in phthisis pulmonalis. Again, if the tubercular matter goes on to softening, and ulceration of the parts takes place, it can be conceived that the coats of the vessels may be destroyed, and, of course, hemorrhage may result.

[The mode in which these results may supervene, was illustrated by sketches on the black board.]

These cases are of frequent occurrence, and the importance of hæmoptysis as a diagnostic and prognostic sign must vary with the circumstances under which it has been produced. When it takes place in an individual whose lungs are free from all disease, it is of comparatively little consequence, being the result of simple hyperæmia, and the consequent transudation of the blood through the parietes of the vessels. But where it occurs in one of tuberculous diathesis, it is a most important phenomenon, inasmuch as it is symptomatic either of the first stage of tuberculosis, or of confirmed phthisis.

In the case of the patient now under consideration, we have an instance of the second form—that resulting from the formation of a cavity and ulceration of the vessels, and the hæmoptysis is, therefore, of serious import.

Combining this last phenomenon and the other vital manifestations with the physical signs, the diagnosis of pulmonary consumption in this case is well marked, although the individual's age, 60, is

beyond that at which the disease usually makes its appearance.

The treatment of hæmoptysis, it need scarcely be said, must vary with the condition under which it occurs. In the present case it merges into that adapted for phthisis, which consists essentially in the use of general and topical revellents, the repeated application of counter-irritants to the thorax, with the use of cough mixtures and other palliatives. Although in cases of symptomatic hæmoptysis like this, little can be expected from remedial agents, we are called upon to prescribe something, and recourse is usually had to a combination of sedatives with astringents. Perhaps there is no better compound than the following:

R. Acid Sulph. dil.
Tinct. Opii.
— Digit. aa. ʒij. M.

Fifteen drops to be taken three or four times daily. The opiate here is adapted for allaying irritation; the digitalis for moderating the activity of the circulation; and the acid may act, to a certain extent, as an astringent.

ENCEPHALIC TRANSUDATION—HEMIPLEGIA.

The Professor next directed the attention of the class to two cases of a similar character with the last, but where the effusion of blood was into the brain.

In these cases, there generally is precedent softening of the cerebral neurine, whereby the vessels receive less support than they ordinarily do, or the coats of the vessels are themselves diseased, or there is a combination of these pathological conditions. Such being the state of the parts, it is very obvious, that transudation of blood must take place readily under favourable circumstances, as in hyperæmia of the brain, or where impediment exists to the encephalic circulation.

One of the patients, a man, was attacked whilst asleep; for his statement is, that on awaking, prickling sensations were felt by him in various parts of the limbs; and there was a diminution of motive power on one side of the body. His locomotion is, even now, not very good, the gait being tottering. In the second patient, a female, there is great loss of power over the extremities of one side, especially of the left arm and hand. She experiences great difficulty in rising from a chair, or walking, and her face is distorted. In her case, there was more marked than in the last, what is commonly termed a "paralytic stroke." She suddenly fell from her seat, and though sensibility was retained she lost all power of motion in the affected side. A striking phenomenon occurs in all these cases; the effusion of blood always takes place on the side opposite the one which is paralysed—the cause of which, the Professor remarked, would be explained on some subsequent occasion.

In the treatment of these forms of transudation, the resources of art are very limited. There is often vascular excitement at first, which may require blood letting or other antiphlogistic means, but the subsequent condition is far from being one of excitement. Frictions, stimulating liniments, electricity, &c. are employed to the paralyzed extremities, but they are of very little efficacy, as the cause remains beyond our control: the clot of blood existing in the brain can only be removed by time: and we must rely mainly on the recuperative powers. But even after the absorption of the clot, there is not a complete restoration to health, for an apoplectic cell may remain—

the evidence of previous encephalic hemorrhage—which, occupying as it does the place of some portion of the cerebral mass, must necessarily prevent the entire restoration of the lost functions.

In conclusion, the Professor exhibited some interesting

PATHOLOGICAL SPECIMENS

from a case which had fallen under his care in the wards, the history of which he gave. When he first took charge of the wards, this fall, his attention was directed to a female with enlarged abdomen, and dropsical effusion into the limbs, who was admitted for, and cured of intermittent fever, and was discharged, but for some reasons she did not leave the house. He did not examine the case at the time, but requested the resident physician to investigate the pathological cause of the phenomena. She proved to be pregnant, and, from her own statement, was at the seventh month of utero gestation. At his next visit, the lecturer found that the areolæ were not of darker colour, but there was the usual development of the sebaceous follicles observed in pregnancy, which is considered by some as a more certain indication of pregnancy, than that derivable from the hue of the areolæ. The fact of her being pregnant was conclusively proved, however, by means of auscultation, the circulation of mother and fœtus being very perceptible. The œdema, therefore, in this case, was accounted for by the pressure of the gravid uterus on the iliac vessels, causing an effusion of the serous portions of the blood into the cellular tissue.

On the 7th inst. the patient became very much depressed in spirits, and during the evening was seized with convulsions, which, from their violence, it was feared, would produce premature labour. Examination was made if any indications of uterine contractions were present, but the neck of the uterus was found not yet obliterated, and consequently she was not transferred to the obstetrical wards. A mercurial cathartic was administered, the tongue being dry and furred. The patient remained obstinately mute, refusing to speak with any one. On the evening of the 10th, a second spasm occurred, accompanied with pains, referable to the uterus. The resident physician in charge of the ward found her on his visit in a profuse perspiration, with a rapid and full pulse—inordinate action of heart, cold extremities, left leg very œdematous, incontinence of urine; veins of the head very much congested, and the countenance distorted. She appeared unwilling to speak, but was perfectly conscious. A second examination, *per vaginam*, discovered no alteration in the condition of the uterus. The attending accoucheur was now requested to visit her, who detected slight uterine contractions, which produced, however, no dilatation of the os uteri. He ordered twelve cups to the back of the neck, to be repeated if necessary; neutral mixture every two hours, and a blister to each ankle.

The patient continued in this state of apparent hyperæmia of the brain; and was very restless. She became gradually worse from this time, and died on the 12th instant. On the day of her dissolution the abdomen was very tympanitic.

On examination, the brain exhibited an injected appearance, particularly on the surface of the hemispheres. The medullary matter on a level with the ventricles was in a state of ramollissement or softening. The other parts of the cerebrum were of the proper consistence. There was an invagination of a portion of the intestine, of four inches in length, but the other parts of the tube appeared healthy. In regard to invagination of the intestines, Professor

Dunglison remarked, that a difficulty might exist in determining whether it was morbid, or had taken place immediately preceding dissolution, owing to the irregular peristaltic action apt to occur under such circumstances. Invaginations are often met with in children, produced in the latter manner. The distinction between these—what may be called—*healthy* and the *morbid* invaginations, he observed, is easily made. If gentle traction be exerted on the intestine, and if it be not morbid, the invagination is readily withdrawn; but if morbid, in consequence of the effusion of lymph between the two peritoneal surfaces in contact, the parts become united. In this case, there was no morbid state of parts, as the invaginated portion was withdrawn with great facility, and consequently it could not be considered as having produced death. Moreover, with the exception of the tympanitis there was no evidence, during life, of intestinal lesion. The true cause of death was doubtless seated in the brain.

The placenta and cord attached to the uterus were exhibited to the class, but no morbid appearance was presented by them. The lecturer remarked, that he embraced the opportunity to exhibit them as physiological specimens.

PROFESSOR PANCOASTS CLINIC, (SURGICAL.)

Reported by Edward R. Squibb.

Saturday, Nov. 9, 1844.

The Lecturer commenced by saying that it was not customary for him in that place, to occupy much time in remarks prefatory to his course of Clinical Lectures. He restricted himself, therefore, to a few observations in reference to the arrangements made by the Managers of the Institution, for the purpose of diffusing as widely as possible, the facilities of the house for clinical instruction,—alluded to the spacious surgical wards of the house, and the great number of patients they contained, which yielded opportunities during the season for the illustration of a great variety of surgical affections. It was probable that in the course of the winter the class would have an opportunity of witnessing many operations. But, he stated, that it would be his particular object to attract attention to that which was less well described in books, namely, the diagnosis, pathology and treatment of surgical diseases; and should the treatment fail to effect a cure, the operations would then be considered, which as a last resort are rendered necessary, either to save the life, or diminish the sufferings of the patient, or facilitate the progress of cure that would otherwise be protracted.

The operation of Lithotomy, which he had expected to perform to day, had been necessarily postponed in consequence of the suffering of the patient from a severe fit of stone, attended with a suppurative discharge from the bladder; but he remarked that if the patient improved sufficiently, he would probably bring him forward on a subsequent occasion.

The first case to which the attention of the class was directed, was one of a very interesting character, from its nature, as well as from the many difficulties which it presented to successful treatment. It was that of a young gentleman from Tennessee, in whom the excessive use of mercury, fourteen years ago, had been followed by extensive destruction of the right cheek, lip, and ala of the nose; one of the consequences of the healing of the ulcer had been the formation of a band of cicatrix between the jaws, as large in diameter as the tendo-achillis, fastening them immovably together, and constituting a false ankylosis.

This having occurred prior to the period of second dentition, the permanent teeth when they appeared, grew very irregularly; some of them projecting through the opening in the cheek, owing to the obstruction presented to their natural course, leaving fissures through which alone, the patient had been able to take his food for 13 years.

The indications to be fulfilled in such a case are three in number; namely, to render the jaw movable, to replace the soft parts of the cheek and lip, and to restore the side of the nose; the two last of which must be fulfilled by plastic operations: to accomplish these objects successfully will require some time, as each is to be attained by a separate process, that should be finished before the next is attempted.

The first operation, or that for the cure of the ankylosis, is one always modified by the nature of the obstacle to be overcome. If the ankylosis was true, or consisted in a deposition of bone in and around the joint, no operation of the kind which I propose here would be available or proper. In such a case nothing but the establishment of a false joint as proposed by Dr. Barton of this city, by sawing through the bone below its condyles, and keeping up a motion in the parts during the process of healing, could be attempted with any probability of success, and this, the result of which would necessarily be doubtful, has not yet been practised upon the living subject. On the other hand—and hence the necessity of a correct diagnosis,—when the ankylosis is false, or does not consist of a bony deposit, the joint remaining with all its structures for motion perfect, as evinced by the scarcely perceptible motion which we here give to the jaw, the means of relief are much less difficult, and to be undertaken with greater chance of success.

The resistance to be overcome in the case before us, is made by what was technically called by Delpech *inodular tissue*, the result of the organization of effused lymph on the inner suppurating surface of the ulcer in the cheek, left by the detachment of the slough. This lymph undergoing gradual condensation during the healing process, has passed through the phases of cellular and fibrous tissue, and in this instance presents to the touch a feeling of hardness almost like that of bone. The band is here short, but very thick and strong, being attached by its extremities to the outside of the gums of the upper and lower jaws, and by its outer surface to the remaining fragment of the cheek. In operating upon such cases, simple division of the band of cicatrix is not found sufficient to effect any lasting benefit, for union is quickly re-established in despite of every effort to prevent it, and the parts return to their former condition. The whole of this inodular tissue should therefore be removed by excision; to do which, however, I have never found it necessary,—as recommended, and practiced by Dr. Mott, of New York, in one case—to lay open the cheek from the corner of the mouth to the ramus of the jaw, in order to render the band accessible, allowing the edges of the wound in the cheek to cicatrize until the play of the jaw was restored, and then excising the edges and closing them as in the hair lip operation. In every case as yet, I have been able by drawing back the corner of the mouth, to divide the band by two or three cross cuts, and extirpate it in separate portions. In the case before us, in consequence of the loss of structure in the cheek, the extirpation is rendered more easy than usual.

The fixed condition of these parts for thirteen or fourteen years will not admit of our supposing the patient capable of opening his mouth immediately on the division of the band, for the muscles, viz. the masseter and temporal, after remaining in a state of rest

for so long a time lose their disposition to relaxation, and become fixed in their shortened state, like the firmly retracted muscles in club foot; hence the necessity will arise after the section of the cicatrix of using some mechanical means whereby the jaws may be separated and these muscles extended and placed in the condition necessary for the exercise of their functions. For this purpose the old jaw dilator of Heister, consisting of two hinged plates, which are forcibly separated by means of a screw, answers very well. In case these means should fail in separating the jaws to a sufficient extent it may become necessary to divide one or both masseter muscles. The patient, who is somewhat interested in the progress of medical and surgical science, has with some philosophy made up his mind to have the operations exhibited to the class, and by this he places it under some obligation.

Operation.—(The first step of the operation was then performed, viz., the separation of the skin from the cicatrix, then a separation of the cicatrix from the bones, thirdly, the removal of the cicatrix which was found exceedingly firm and hard.) After this removal of the band the jaw is found to yield somewhat, but upon further inspection the gums, where the double teeth should be, are found adherent, and it becomes necessary to dissect them apart. The anterior part of the right masseter muscle also appears so much contracted as to require division, which I shall now make from before backwards with the bistoury. I now apply the dilator, and by its means the jaws are separated without much difficulty; by extending its application to the other side, still more space is gained.

The jaws are now opened to the extent of an inch, and with this we shall have accomplished sufficient for the day. We shall direct the daily application of the instrument in order gradually to increase the separation to the natural extent; keeping during the intervals pieces of cork interposed between the teeth, in order to preserve the space we gain. There is one fact recalled to my mind by this case, which is curious and worthy of notice, namely, that the teeth in such cases although never used in mastication, are almost always found to be carious.

At future meetings the remaining steps of the operation will be successively exhibited.

The next case to which the Professor directed attention, was one in which a chancreous affection of the glans penis had resulted in destruction of the glans, and the anterior extremity of the corpus cavernosum, and in the obliteration of the anterior portion of the urethra, with a phymosis-like contraction of the integuments around the end of the stump.

In 19 out of 20 cases of obliteration of the urethra, with the formation of false passages for the urine, ulceration of the urethra takes place behind the scrotum, and the consequent infiltration of urine causes a fistulous opening in some portion of the perineum by which the fluid escapes. In the present case, on the contrary, this ulceration has occurred anteriorly to the perineum, and the urine has found its way into the corpus cavernosum, the cells of which are filled by it like a sponge, and the organ, from this cause, and from the inflammatory hardening of the parts, is maintained as it were in a constant state of erection, having more the appearance of that of one of our large domestic animals than that of a man. The injection of the urine into the corpus cavernosum in attempts to evacuate the bladder, has led to the establishment of these fistulous ulcers leading from the cells outwards on the body of the penis, through which, as exhibited by the lecturer, the urine can

be at any time forced in small jets by pressing upon the distended body of the organ.

What is most astonishing in this case, is that this condition has been maintained for a space of two or three years without the occurrence of gangrene or sloughing of the parts: for one might have supposed it would have been attended with such consequences, or even have caused the death of the patient, for the rapid injection of urine into a highly organized part, is, from the irritating properties of that fluid, in common quickly followed by such disastrous results.

The plan by which I sometime since proposed to relieve this man, and which possibly will be adopted if he should make up his mind to bear the operation, was by a button hole incision into the posterior part of the urethra, to divert the flow of urine entirely from the corpus cavernosum; through which incision, after the fistulous openings in the body of the organ had closed, a trochar might be introduced and pushed out to the end of the penis, making a new urethra into which could be inserted a silver catheter in order to prevent the collapse of the new opening before its walls should have acquired the necessary firmness.

This, as remarked by the lecturer, is altogether a very singular case, and without counterpart in the annals of surgery; both from the anomalous course pursued by the urine, the position of the fistulous sinuses, and particularly from the impunity with which the vascular structure of the cavernous body has borne the presence of the irritating urine for so long a time.

The third case I present is one (a deep-seated oblong tumour in the perineum) which at first sight appears to be somewhat obscure.

But when we reflect upon the rarity of tumours occupying the anterior part of the perineum, except from one cause, namely, obstruction to the natural course or flow of the urine, (and we find that this patient has suffered for a long time from stricture of the urethra,) much of the obscurity will be dissipated. It is true that a common phlegmonous tumour, or enlarged muciparous glands, may appear in this situation, or there may be a hardened tumour of the parts, extending forwards, as the consequence of a stercoral abscess by the side of the rectum. But a careful inspection of the parts, with a close inquiry into the history of the case, will often serve to show the connection of these deep seated tumours in the front portion of the perineum, with a pre-existing lesion of the urethral passage—consisting in some form of stricture, injuries received upon the parts, or even from rough catheterism of the passage—indicating their dependence upon the escape of a small amount of urine into the cellular tissue between the inferior and middle fasciæ of the region.

Here we have a tumour of considerable size, deeply seated, and firm to the touch, occupying a great portion of the left side of the perineum. The history of its appearance is as follows. Some time since the patient had a gonorrhœa, which was cured, as he says, by balsam, injections, and the subsequent use of bougies. After the suspension of the treatment, he experienced difficulty in micturition, the urine dribbling away slowly, instead of flowing as usual in a continuous stream. This difficulty increasing upon him, he soon after perceived this tumour commencing, and noticed also a slight burning pain after urination, beneath the commencing tumour, which has rapidly increased to its present condition.

We have here then, evidently stricture of the urethra, which too frequently follows such cases of gonorrhœa, and it is worth your while to notice this dribbling of the urine,—the falling of it, guttatim, as

it were, from the end of the penis, as from this we are justified in suspecting the existence of more than one stricture, as I have observed that where but a single one existed, although it may be a narrow one, the urine issues in a continuous stream, and is thrown to some distance, which cannot be the case, where two or more are present, as the force of the current must then necessarily be broken.

By the introduction of a bougie, we find the canal obstructed by a firm stricture just anterior to the bulb, the instrument from its small size, having passed one which is seated nearer to the glans. The first and greatest is however, probably the cause of the tumour, which consists, as I have no doubt we shall find, of an infiltration of urine into the cellular structure, occurring anterior to the triangular ligament, and causing a local point of suppuration there, with the effusion of lymph around it so as to form a hardened base. Before we can expect a radical cure of the case, these strictures must be overcome, either by dilatation or division; but by attempting this in the first place, without giving any attention to the tumour we should subject the patient to the risk of an extensive and deep seated perineal abscess; I shall therefore do what I advise all of you, in such cases, never to hesitate in doing, namely, lay open fully and freely the whole tumour, and discharge its contents, allowing the urine, if it still escapes from the opening in the urethra, a free exit, and converting the affection into a fistula in perineo. This is best accomplished by the use of a sharp pointed bistoury which should be introduced at the posterior extremity of the tumour, in a position at right angles to the surface—and when carried into the cavity, which may be known by the freedom of motion in the point,—the handle should be depressed so as to bring the point out at the adverse boundary of the tumour, when by depressing the handle and cutting outwards the whole tumour is laid open, discharging, as you see, a quantity of urine with pus and blood. By this procedure we have removed the contents of the abscess and prevented its extension, and removed also the compression which it made upon the urethra, which otherwise would have rendered the use of bougies in dilating the strictures extremely difficult, and probably in the previous state of the parts more injurious than useful. As the patient presents the appearance of one with a broken constitution, which condition occurs so commonly in these disorders of the genital organs, he has been placed upon a tonic treatment, consisting of an infusion of uva ursi, buchu leaves and juniper berries with bicarb. of soda, which will be continued. The wound for the present will be simply dressed, and after the oozing of blood from the sides of the incision shall have ceased, be covered by a warm poultice.

Here is the case of a man begging lustily to have his leg cut off, in consequence of caries of the posterior part of the os calcis. This is a favor which, however, we never grant merely at the patient's request, nor ever resort to except in case of great necessity, knowing that it is but a very bad natural leg that is not better than a wooden one. Instead of it, therefore, we shall resort to the less serious operation of modern surgery, that of the excision of the carious bone. This patient has been for some time confined to his bed by this disease of the bone which has led to the establishment of a sinuous ulcer of the heel, from the margins of which these fungous excrescences are growing. This bone by the way, is much exposed to injuries and is peculiarly liable to become carious at its posterior part. Now to remedy this it will be necessary to lay the patient upon his abdomen, lay open the parts freely and remove the cause of ulcer-

ation whether it may be necrosed or carious bone, by means of a saw, raspatory, or trephine. There is one objection to these operations upon the heel, which however cannot be avoided; that is, the fact that cicatrices in this part are almost always painful.

We will now commence, (having a tourniquet at hand in case of hemorrhage) by a semi-circular incision around the back part of the heel, then extending a straight one from the middle of this, through the ulcer, converting the wound into a kind of T shape, whereby plenty of space is gained and the external and internal plantar arteries avoided; upon raising the flaps from the bone, the first thing observed is a piece of dead bone lying partly loose upon the carious surface of the os calcis, after removing which and scraping away the carious surface, which is so soft as to be cut with the knife, we examine carefully with a probe, to see that no diseased portion is left behind; finding a portion still soft, we with the point of a raspatory proceed to remove it, and when all is got rid of, we see a considerable depression is left in the surface of the bone. We next bring the flaps back to their places, with the intervention, however, of a piece of charpie, and over the whole apply a piece of lint spread with cerate,—confine it by a bandage and place the patient in bed, with the leg elevated on a pillow.

The next case to which I will ask your attention, is one of the caries of both phalanges of the great toe with a destruction of the intermediate joint; for which there is no earthly remedy except an amputation at the metatarso-phalangeal joint. Here you see two carious ulcers corresponding with the two bones of the toe, every effort to heal which, and the trial has been a long time making, has proved unavailing. Now there is a very serious objection to removing the great toe, which should always be considered before the operation is undertaken; and that is, by taking it away you destroy a part of the abutment upon which the arch of the foot rests, and therefore create some inconvenience. Many operations have been proposed and used in these amputations; for instance, *Graife*, when the disease did not involve the upper joint, employed the antique method of striking off the toe with a chisel and mallet. This cruel mode I need hardly say, is not used in our day; some recommend us to cut obliquely through the metatarsal bone, in order to avoid an alleged liability to abrasion by preventing the head of the bone, covered only by thin integument, from pressing against the inside of the boot; but if there is any real advantage gained in this point of view, it is more than counterbalanced by the removal of an unnecessary portion of the support required by the inside of the foot. The circular operation is also sometimes used, but that which I greatly prefer to any other is the oval operation of *Scoutetten*. To perform this you commence your incision on the dorsum of the foot a little above the joint, bringing it down between the toes, around, under the bottom and back to the starting point, making a kind of V shaped wound, with the ends of the V joined by a segment of a circle. An important modification, which is rarely noticed in the books, consists in so shaping your incision as to leave more flap upon the margin of the foot than upon the other where the commissure of the toes prevents retraction to any great extent.

OPERATION.

You first bend the toe down and make your V incision, cutting to the bones. Then sever the tendons on the back of the joints; afterwards divide the ligaments, sweep your knife under the bone, and the toe is sepa-

rated. You will generally find but one artery to tie as in the present instance, namely the continuation of the internal plantar. This done you proceed to bring the integuments together by your straps, and if the operation has been properly performed, there will appear to be a superabundance of tissue as you may see; this however is rather apparent than real, as your patient could meet with no greater misfortune than to have the integuments too tight and adherent to the end of the stump, as it would subject him to constant pain and ulceration in the parts. You will often find, too, a portion of the long flexor tendon projecting after the toe has been removed; this should be cut, as tendons give no pain on division except when accompanied by a nerve, as was proved by Mr. Pott upon his own person, and moreover is peculiarly liable if exposed, to slough and give trouble. After well cleansing and drying the parts, you bring them together by straps, over which a piece of lint cut so as to adapt itself to the stump, is confined by a tight roller bandage, applied so as to exercise some compression, which is well calculated to lessen the tendency to inflammatory action, and therefore very important in the treatment.

BIBLIOGRAPHICAL NOTICES.

Cyclopædia of Practical Medicine. Parts XVI and XVII.

The subjects embraced in this work, are treated of in alphabetical order, and already has it extended to *Porri*go. But seven parts remain, in fact, to complete the work; and from the punctuality with which it has thus far progressed, there can be little doubt that in three months from this time, every number will be in the hands of the subscribers. The following are the contents of part XVII, viz.: Peritonitis, Phlegmasia Dolens, Pityriasis, Plague, Plethora, Pleurisy, Plica Polonica, Pneumonia, Pneumo-thorax, Porrigo.

Summary of the Transactions of the College of Physicians of Philadelphia. March to October, 1844, inclusive.

The present summary contains the "*Annual Report on the Diseases of Children*," by Dr. Condie, beside much other useful matter, having a direct relation to every day practice. Dr. Condie's excellent "report" we shall transfer to our columns as soon as we can find space, as also several other valuable articles.

In the present number we have only room for Dr. Bond's interesting case of perforation of the uterus, followed by death, occurring after parturition, which will be found in our *Record*.

Lectures on the more important Eruptive Fevers, Hæmorrhages and Dropsies, and on Gout and Rheumatism. Delivered in the University of Pennsylvania. By N. CHAPMAN, M. D., Professor of the Theory and Practice of Medicine, etc. etc. 8vo., pp. 448. Philadelphia. Lea and Blanchard. 1844.

Very recently we had occasion to chronicle the appearance of a volume "on the Principal Diseases of the Abdominal and Thoracic Viscera," by Professor Chapman, and now we are presented with another, on subjects not inferior in importance to those embraced in the previous publication. Both consist of lectures which the venerable author has been in the practice of delivering annu-

ally, for a quarter of a century, to the largest classes of medical students assembled in the United States. To the many hundreds, nay thousands, who in by-gone days have listened, like ourselves, to the doctrines and precepts they contain, enforced at the time by the impressive manner and elocution of the teacher, these lectures possess a peculiar interest—not for any novelties they contain, but as reminiscences of some of the most interesting circumstances of their youth.

How forcibly we are reminded in the sentiments and language we read, of the old college edifice, stuck preposterously to the side of the magnificent house built for Washington—of its dark passages and sombre halls—its odd windows and uncouth benches—the queer old janitor—the tall person and imposing manner of the lecturer:—how we borrowed a pencil of one or a drop of ink from another, to note down the revelations of science, and the never to be forgotten opinions of the Professor!

Time, which so changes and modifies the opinions of the generality of men, has had little influence over those of our author. The Haightonian doctrine of *sympathy*, espoused and proclaimed in his edition of Burns' Midwifery, thirty-four years ago, and elaborately set forth at a later period in his Therapeutics, still reigns supreme.

The present work would seem, from some expressions of the author, to be designed chiefly for the benefit of his pupils, although its publication is calculated to give it a more extended usefulness. Nevertheless, for general reading, by the following remarks in a prefatory notice, he seems to regard it as not so well adapted; viz.: "As a fragment of a course of lectures, it is deprived of numerous facts or discussions, theoretical or practical, illustrative or exegetical, distributed under other heads, which could not have been displaced and concentrated in it, without a rude violation of the integrity of the plan, and injustice to the entire undertaking. Nevertheless, he trusts that the work does not suffer materially in this respect—and, at all events, that, whatever the defect may be to others, it cannot be felt by his class, by whom the whole course is heard."

Notwithstanding the number and importance of the diseases embraced in the two volumes now published, there are yet many more comprised in a full course on the branch taught by Professor Chapman; and although no such intimation is given by the author, it is not likely that he will leave his work incomplete. The publication of the lectures delivered to his class, at the present time, must be looked upon as a legacy to his pupils and the profession, and it is desirable, therefore, that nothing should be wanting to perfect the series.

THE MEDICAL EXAMINER.

PHILADELPHIA, NOV. 30, 1844.

INTRODUCTORY LECTURES.

The winter courses of lectures having commenced in the various Medical Colleges of the country, we may expect shortly to be supplied with an abundance of these interesting annuals. We shall endeavour, from those sent to us, to cull many a literary flower, and many wholesome truths, "fitly expressed," for the amusement and instruction of our readers.

The "first fruit of the season" is now before us. It

is "On the formation of Professional Character: an Introductory Lecture, delivered Nov. 4, 1844, by John P. Harrison, M. D., Professor of Materia Medica and Therapeutics in the Medical College of Ohio." In this lecture, the Professor treats of the dignity and importance of professional character to a physician, and the proper mode of acquiring it.

The doctrines inculcated are sound, the sentiments expressed are just, and the language employed, although sometimes a little turgid, is the language of generous feeling and honest purpose. At present we can spare room for only one or two brief extracts.

"But what constitutes professional character, and what are the best methods of its formation?"

In the first place, it is constituted of attainments, intellectual and moral. The mind must be cultivated, and the moral feelings disciplined in order to attain a sound and stable professional character. The intellect must be furnished with a correct and enlarged conception of the subjects pertaining to the science of medicine. No deficiency, derogating from the great beneficent uses of medical knowledge, should exist in the mind of the physician who aspires to the acquisition of an authentic professional character.

The elementary branches of medicine must be thoroughly studied, and after the mind is deeply imbued with substantial information on anatomy, physiology, chemistry, general pathology, general therapeutics and materia medica, then the practical branches are to be mastered. Hospital practice in medicine and surgery, as largely contributing to the establishment of a correct judgment of disease, and of the different means of cure, should be assiduously prosecuted. However valuable are the general attainments of the student, and however diversified and minute may be his knowledge of medicine in its principles, yet without personal observation, the recognition and treatment of the various maladies to which mankind are incident, must remain imperfect, and uncertain."

The correctness of these observations must be admitted by every intelligent physician. The remark in reference to Hospital practice is especially important, particularly at a time when the institution of numerous Medical Colleges in places which afford no clinical advantages, makes it the interest of so many to decry the value of such instruction. To what does Philadelphia owe her supremacy as the great seat of medical education in the western world? Undoubtedly to the number, extent, and admirable arrangement of her public institutions, at which clinical advice and instruction are regularly given by her ablest and most experienced physicians and surgeons. At this moment nearly *nine hundred students* are in attendance upon the lectures at her Colleges—a number unexampled in her past history, and unequalled at the present time, except in two or three of the large cities of Europe.

RECORD OF MEDICAL SCIENCE.

CASE OF DEATH AFTER PARTURITION.

BY DR. BOND.

April 8th, 1844. At 10 P. M., he was requested to visit Mrs. R—, and was informed by the messenger that she was affected with cholice. Mrs. R. had a good form and constitution, and enjoyed good

health until this attack. She is twenty-eight years of age; was married on the 4th of last October; had never menstruated after marriage; supposed that she became pregnant within one week after that event, and expected to be confined in the beginning of the second week in July. About noon to-day she was reaching over a flour barrel that stood end-wise, to pick up something behind it, in doing which she felt something give way, and was attacked with pain in that part of the abdomen where she came in contact with the sharp edge of the barrel. The pain continued all the afternoon and evening, and was supposed by her female attendants to be colic, and, in consequence, ginger tea and other domestic remedies had been administered. But the pain became worse in the evening, and when the doctor visited her, she evidently had labor pains, but no stools or discharge; he directed her an opiate, rest, and a cool regimen, with orders to send for him if she was not shortly relieved. At 11½ o'clock, P. M. he was sent for again. The pains had increased, and the os uteri had become relaxed, and more than half dilated. The pains were more distressing than usual in such cases, and she was inclined to keep her hand applied to that part of the abdomen which had come in contact with the barrel. The membranes were very strong, and continued unbroken, until a loose sac of water presented externally, and when broken, there was a gush of a large quantity of liquor amnii. The delivery of the child followed almost immediately afterwards—April 9th at 2½ A. M. Soon after this, he began to use the ordinary means to promote the delivery of the placenta, which he continued to do for three quarters of an hour without any effect. There was no sign of its coming; there was neither any expulsive pain, nor the least appearance of any coloured discharge. He then gave twenty grains of ergot, and after a quarter of an hour, twenty grains more. At the end of ten or fifteen minutes more, no uterine contraction had occurred,—at least he discovered none, either by questioning the patient or by watching her motions. It is proper to observe, that the ergot, although procured at the time from one of the best shops, was almost entirely destitute of the peculiar odour which he had generally observed to belong to that which has been most effective.

The uterus was so low that he could easily pass his finger within its neck which was soft and relaxed; but above that, the uterus seemed to have assumed something like an hour-glass contraction, so low down towards the neck, as to embrace in the upper chamber nearly or quite all of the placenta. He then prepared to introduce his hand, without waiting longer for the ergot to act. The cord was ten inches long, very large, and firm for that period of gestation, except for a short distance near its insertion into the placenta, where it was very slender. In his attempts to examine the condition of the uterus and to deliver the placenta, the cord was torn from its attachment. This occurred only a short time before the introduction of the hand. The os externum and the os cervix uteri were so relaxed, that the hand passed with ease until it reached the above mentioned contraction. This was so rigid as to occasion some delay. During the process of introducing the hand, pretty strong uterine contraction came on, which increased the delay. Whether this was the effect of the ergot, or of irritation of the hand, is doubtful;—probably it was partly owing to each. Upon passing the hand through the stricture, into the chamber containing the placenta, it was found that this was detached from the uterus in no part, so far as could be perceived. Up to this period there was no sanguineous

discharge, except a very little, which was supposed to proceed from the separation of the cord. The doctor proceeded slowly and carefully to detach the placenta, which adhered so firmly as to make the operation tedious. After the whole of the placenta was separated, he found a strong membranous attachment to one part of the fundus, which he could not overcome. It was of limited extent, being less than an inch. He used as strong traction as he thought could be done without endangering a laceration of the uterus. When pulling it, it seemed to yield a little, but upon examination, there was no sign of its being detached. It occurred to him that, possibly, there might be an hour-glass contraction, embracing a small part of the placenta and membranes, although he could perceive no rounded edge and depression around the adhesion such as he should expect in that case; but to determine this, he applied the other hand to the abdomen, and this examination entirely satisfied him that such could not be the case. He then separated the placenta from this adhering membrane, and withdrew it. The membrane, which felt like a ligament, had such remarkable strength, that the separation was not easily accomplished. The operation occupied three quarters of an hour, and was attended with very little hæmorrhage.

The child lived twelve hours. The foetal end of the cord, as before observed, was very thick, and he tied it, as he thought, very carefully: but in a little while he discovered that, in proportion to the size of the child, there was considerable hæmorrhage, such as might have destroyed it, had it not been discovered and arrested. It had not, however, produced, any signs of anæmia.

April 10. Last evening the patient began to be uneasy, and feverish—a cathartic of senna, manna, and sulph. magnesiae, in divided doses was directed. It operated sufficiently during the night, but the febrile symptoms and uneasiness were not mitigated. Tongue a little coated; pulse 110 to 120; some tenderness in the left iliac region; the uneasiness in the head increased. In the afternoon the symptoms all aggravated; no lochial discharge. Directed the neutral mixture; v. s. oz. xxiv; fomentations. The blood drawn exhibited a thick buffy coat, and small cupped coagulum.

April 11. Head much relieved since the v. s. but the patient had a very uncomfortable night; tongue has a yellowish white coat, thickest in the middle; had a severe chill this morning at 7 o'clock; pulse 120 to 130. After the applications of the fomentation, a copious sanguinous discharge from the vagina came on, which it was thought desirable to promote, therefore the v. s. was not repeated nor leeches resorted to this morning as would otherwise have been done. Directed cal. ipecac and opium. At 5 P. M. pulse 102, at 11 P. M. 82; all the symptoms mitigated. The pain in the abdomen, last night and to-day, which was almost entirely confined to the iliac region, was intermittent like after pains.

April 12. In the morning found her more comfortable in every respect; pulse 80 to 90. No tympanitis or swelling of the abdomen, and the tenderness is chiefly confined to the part before mentioned; sanguineous discharge has ceased, and the vaginal discharge has become offensive; some confusion of the head in the night and this morning. When visited at 5 P. M. the patient was found to have become worse soon after the morning visit; great increase of febrile excitement and of tenderness of the abdomen; thirst great; began to be tympanitic. Upon examination found some shreds of membrane in the neck of the uterus, which were removed; one part,

however, extended into the uterus, which could easily be seized hold of, but adhered too firmly to be extracted without applying more force than could be done with safety. Sometime afterward it came away and the offensive discharge ceased.

April 13. She began in the night to belch up whatever she drank; pulse very variable; tympanitis increasing, as well as the distress and tenderness in the abdomen. Dr. Meigs saw the patient twice to-day, but it is unnecessary to detail the treatment which had no influence in controlling the disease. The discharges from the stomach became more and more dark, until they closely resembled coffee grounds. The patient grew rapidly worse, and died next morning, April 14th, at 4 A. M., about 98 hours after delivery.

Autopsy, 29 hours after death. The operation was performed by Dr. Goddard, in the presence of Drs. Huston and Bond; and this account of it is chiefly taken from Dr. Goddard's notes. Abdomen alone examined. On opening the peritoneal cavity, a quantity of foetid gas escaped, which occurrence Dr. G. observed he had never met with, except in cases of perforation of the intestines, or as a result of putrefactive fermentation. That part of the peritoneum, where this gas was contained, was dry and glossy, as if it had been hung up in the open air; colon much distended and very low in the abdomen. Upon carefully raising the omentum majus, the whole of which was gangrenous and foetid, a black mass, about two inches long and three quarters of an inch wide, was brought into view, one end of which passed into an opening in the fundus of the uterus. At first view this looked like a coagulum of blood, which in some parts had begun to be organized, but which, being drawn out and washed, proved to be a portion of the foetal membranes, with some remains of placental fibres, and the debris of a coagulum of blood—the whole being in an advanced state of putrefaction. The uterus was next examined, and found to be lacerated at the left extremity of the fundus, above and very near the junction of the Fallopian tube. The rupture in the peritoneum was small—about three-fourths of an inch in length, and entirely filled up by the membrane before alluded to. The laceration of the proper substance of the uterus was greater, and its edges were covered with a coagulum partially organized. The lining of the uterine cavity elsewhere looked well. The peritoneum showed traces of high inflammation in several parts—about the stomach, among the small intestines and especially at the pelvic region, but appearing comparatively healthy at the anterior portions of the abdomen. There was very little effusion into the peritoneal cavity—there was a small quantity of blackish fluid, with flakes of pus floating in it, in the most dependant portions of the abdominal cavity.

There is, therefore, reason to believe that, when the laceration took place, it was chiefly in the uterine substance, the peritoneum resisting; that the unbroken membranes protruded, like a hernia, through the aperture into the abdominal cavity; that the contraction of the uterus, after the delivery of the child, closed so firmly upon these as to strangulate them, and to resist the efforts to withdraw them, during the operation for extracting the placenta. This examination explains the difficulty attendant upon the delivery of the secundines; for although the placenta was in no part detached from the uterus when the hand was first introduced, still there did not appear to be any preternatural adhesions or growing of the placenta to the uterus; but the chief difficulty arose from the extraordinary strength of the foetal membranes, and

their inextricable confinement. The revelations of this examination, were especially gratifying to the doctor, as he had apprehensions before this, that although the labor was brought on by an accident, the febrile and inflammatory symptoms and the fatal termination, might have been the consequence of the operation of extraction; although he had proceeded with such caution, that he was satisfied it could have resulted only from the irritation of the protracted operation, and not from any laceration, or other violence done to the part.

Dr. Bell remarked, that the case just detailed was certainly a highly interesting one. From the known experience and caution of the gentleman by whom they were performed, there could be no doubt but that the measures pursued, with the view of detaching and bringing away the placenta, were conducted with due care; there was, however, he was convinced, far too much anxiety, in general, entertained in regard to the retention of the placenta, or any portion of it over a certain period, within the cavity of the uterus, and not unfrequently, he apprehended, injury has been inflicted upon that organ by the efforts made to bring away the placenta, especially by the introduction of the hand; and when a preternatural adhesion of the placenta to the surface of the uterus exists, it is to be feared that its forcible separation may be the cause of some serious lesion, even laceration or rupture of the walls of the uterus. If no immediate ill consequences result from the retention of the placenta, would it not be better in every case to wait, until it is thrown off by the contraction of the uterus, which may be accelerated perhaps by friction, slight traction of the cord and similar means. Even when the retention results from preternatural adhesion of some portion of the placenta, if it cannot be entirely detached without the exertion of more than the slightest degree of force, it will certainly be separated after a time, and discharged with the lochia. On the experienced and careful obstetrician the importance of caution in regard to this subject need not be enforced, but the young, and inexperienced practitioner should be as much as possible dissuaded from every species of interference, in any case of labor, in which it can, with safety to the patient, be possibly avoided. We are convinced, that in the practice of midwifery much less danger is liable to result from patiently waiting for the operations of nature, which, though often tardy, are in the end seldom inefficient, than from too rash and early a resort to instrumental assistance.

Dr. Moehring would inquire, whether any of the Fellows present had ever known injury to result from waiting until the placenta was expelled by the action of the uterus—the usual means being in the meantime resorted to to induce its complete contraction. Several of the continental writers on obstetrics forbid all interference, excepting in cases where profuse hæmorrhage or other alarming symptoms occur—he had himself allowed the placenta to remain for a day or even longer, when it came away without any injury or suffering to the female resulting. He believed that the danger from retention of the placenta for many hours after the birth of the child was overrated by many practitioners, and that this often caused a too early and improper interference in order to effect its removal.

Dr. Condie remarked, that he had supposed the rules in regard to the management of the placenta to be well settled; he was not aware that any important difference of opinion existed on this subject among the practitioners of midwifery in this country. The direction given by the late Professor James was, ex-

cepting in cases in which the occurrence of hæmorrhage or other alarming symptoms demanded its earlier removal, to wait for at least one hour after the delivery of the child for the expulsion of the secundines, when, if this did not occur, to introduce the hand and remove them—but in no case to leave the patient until the placenta was brought away, and the uterus well contracted. This direction, he is convinced, is a very judicious one. A very common cause of retained placenta, being an hour glass contraction of the uterus, some have even advised that in all cases, when, after the delivery of the child, the placenta is found not to come away, upon gentle traction of the cord and brisk friction over the region of the uterus being resorted to, that its delivery should be effected by the hand, inasmuch as the partial contraction is then much more easily overcome than it will be at a later period. The rule being understood, that whenever the placenta is not expelled by the action of the uterus within a short period after the birth of the child, manual interference is required, the precise time it is proper to wait in each case must be left to the judgment of the practitioner. In some, it may be necessary to bring away the placenta immediately, while in others, an hour or two may, with great propriety, be allowed to elapse before this is done. In general, however, he believed that the sooner the placenta is delivered the better. The practice of leaving a female with a retained placenta, and waiting many hours or even days for its discharge, cannot be too strongly reprobated—it being attended always with the utmost risk to the patient. The doctor stated that he had known, when this practice had been pursued, the patient to become exhausted by an almost continued hæmorrhage, which ceased almost immediately after the placenta was removed. In other instances, when the entire placenta, or a considerable portion of it has been allowed to remain and become putrid—all the symptoms of a low typhoid fever ensued, under which the patients sunk. By more than one of the recent writers on obstetrics, the danger of allowing any portion of the secundines, or coagula of blood to become putrid in the cavity of the uterus, is very strongly insisted upon, and it is even recommended that injections of some tepid fluid should be resorted to, in order to wash out the uterus and vagina. The origin of one of the most unmanageable forms of puerperal metritis, has been ascribed to the absorption, by the open mouths of the uterine veins, of putrid matter, resulting from the retention and decomposition within the uterus, of portions of the after birth, or coagula.

Dr. Bell did not doubt that cases might occur in which the prompt removal of the placenta would be called for—but he was persuaded, that in the generality of cases, less danger will be liable to result from waiting until it is thrown off by the action of the uterus, than from the injury which must, to a greater or less extent, be inflicted upon this organ, already predisposed to disease, by the introduction into its cavity of the hand and the manipulations necessary to separate, grasp, and bring away the placenta. In some cases, the connection of the latter with the uterus is so intimate, that, we are told, much time and some degree of force are required completely to separate it. Is it possible to suppose that the delicate texture of the uterus can escape in such cases without injury? It is said that there is danger of hæmorrhage so long as the placenta remains undelivered. This may be true in certain cases, but does it not depend upon the very same circumstance which causes the after birth to be retained; namely, the imperfect contracting of the uterus; and will not a resort

to those means which tend to excite contraction of the uterine, enables us to control the hæmorrhage, and at the same time cause the expulsion of the placenta? The supposition that puerperal or any other malignant form of fever will be produced by the retention and putrefaction of the placenta is extremely problematical. It is not uncommon for a portion of membrane or coagula of blood, subsequent to parturition, to become putrid within the uterus, and be discharged in this state with the lochia—and yet we know, that puerperal metritis or typhus fever is of comparatively rare occurrence. The doctor remarked, that it was not his desire to advocate a universal rule of non-interference in cases of retained placenta, but to urge the necessity of trusting in these, as in all the ordinary cases, and throughout every stage of labour, much to the operation of the natural powers, and of avoiding all unnecessary and too early interference.

Dr. Warrington had always acted upon the rule of not leaving his patient until the placenta was expelled, and provided this does not take place spontaneously, within a reasonable period after the delivery of the child, to introduce the hand and extract it: it had nevertheless fallen to his lot to observe a few cases, in which the placenta was allowed to remain for many hours—in one for twelve hours—without the occurrence of any injury or suffering on the part of the patient. He believes the safest rule to be, however, to wait for an hour, and if the placenta is not then expelled—frictions over the hypogastrium, gentle traction of the cord, and perhaps the administration of a dose of ergot, having in the meantime been resorted to—to deliver by the hand.—*Trans. College of Physicians.*

CREASOTE IN NÆVUS MATERNUS.

Dr. Thornton informs us that of all the applications he has tried in nævus, (telangiectasis,) the most effectual is creasote. He had treated three cases in the course of the year successfully with this substance. It is applied two or three times, daily, more or less diluted. Excoriation, ulceration and gradual disappearance of the nævus ensues; the cicatrix has always been smooth and sound.—*Lond. Med. Gazette, from the Medicinische Zeitung.*

POISONING BY CORROSIVE SUBLIMATE.

Dr. Watson, of the Royal Infirmary, at Glasgow, records in the London and Edinburgh Medical Journal, a case of poisoning by corrosive sublimate, which occurred in his practice, the principal features of which were that, although the patient lived seven days after having swallowed the poison, no real salivation took place. The gums were only slightly swollen; there was no mercurial fætor; the teeth were firm; and the flow of saliva was confined to the first day after admission into the hospital, when it might be partly occasioned by nausea, but especially by the irritation of the fauces, and difficulty of swallowing. The effects of the poison were confined to the alimentary canal, or nearly so, but the whole track of the canal was not equally acted on: the œsophagus, the left half of the stomach, the lower part of the ileum, the colon, and especially the rectum, were chiefly affected; and those parts, although the seat of violent action, were free from abrasion. The urinary bladder, and the lining membrane of the larger bronchi, had also participated, although in a minor degree, in the general irritation of the mucous membrane. Chemical analysis did not detect any traces of the poison in the alimentary canal. The liver, in which Orfila has recently discovered indica-

tions of corrosive sublimate in cases where it has been administered internally, does not appear to have been examined chemically.—*Lond. Med. Times.*

USE OF CHLORIDE OF SODIUM IN DISEASES OF THE EYE.

Dr. Taignot (L'Experience) employs the chloride of sodium, as a topical application, with advantage, in the treatment of different forms of inflammation of the eye, and more particularly in ulcerations of the cornea, in the form of ointment or collyrium, and sometimes even in substance. He considers it to be more efficacious than nitrate of silver, and other substances which are commonly applied, in such cases, and less likely to produce permanent irritation, or to act as an escharotic. The ointment is prepared in the proportion of one to four drachms of common salt to the ounce of lard; the weakest preparation being used at the commencement of the treatment, and the collyrium is made with from one to three drachms to the ounce of water. One drachm to the ounce will be sufficiently strong for ordinary cases.

Ib d.

POISONING BY SULPHATE OF IRON.

A case of considerable importance in a medico-legal point of view, is reported in the London and Edinburgh Medical Journal, as having occurred to Dr. Christison. A child, four years of age, having died in circumstances which excited strong suspicions of poisoning, an investigation was made by the law authorities nearly four months afterwards. The symptoms presented by the child were violent vomiting and purging coming on after breakfast, followed by death in the afternoon of the same day. The suspected person was proved to have purchased both sulphate of copper and sulphate of iron not long before, and was seen by other children to mix a blue liquid with the porridge, and to give a blue liquid for drink after the symptoms began. Copper was naturally suspected, but there was not any found, either by the Messrs. Dewar, who conducted the first analysis, nor afterwards by Dr. Christison; but there was obtained a large quantity of iron, partly in the soluble condition, but chiefly in the form of a compound insoluble in water. This appeared to be in a great measure sulphuret of iron, formed by the decomposition of the sulphate, through means of the sulphuretted hydrogen and ammonia, disengaged during the decay of the body, for water which had acted on the contents and textures of the alimentary canal, presented evidence of a much larger quantity of sulphuric acid than would have arisen from the ordinary contents; and the whole course of the mucous coat from the mouth to the anus, was thickly lined with a layer of jet-black mucus. The tissues of the stomach presented everywhere the same colour. Iron was also found largely in numerous brown stains on the child's clothes, and the apron worn by the person suspected to have administered the poison. Messrs. Dewar made some experiments with sulphate of iron, from which they came to the conclusions arrived at by Orfila and Smith, that two drachms retained in the stomach by a ligature on the œsophagus will cause death in a few hours. The process employed for detecting the iron, consisted in incinerating the contents and textures, acting on the residue with diluted nitric acid aided by heat, adding an excess of ammonia, and transmitting sulphuretted hydrogen. The ammonia separates a yellowish precipitate of sesqui-oxide of iron, and does not render the liquid blue, if there be not any copper. The sulphuretted hydrogen then produces black sulphuret of iron.

Ibid.

NOTICE OF THREE CHILDREN AT A BIRTH.

BY ROBERT ANNAN, ESQ., SURGEON, KINROSS.

Mrs. S., robust, of ordinary height, the wife of a manufacturer in Kinross, aged 38, the mother of seven children, was taken in labour, about 5 p. m., on the 16th of April, 1844. From her uncommon size, and having had twins at her previous confinement, the labour had been looked forward to with some anxiety. About 12 p. m., she was delivered of a female child, of full size. A ligature being passed on the cord (and the mother fully anticipating a second child,) the head of another, and feet of a third child were found presenting. As the head had advanced considerably, no time was lost in pushing back the feet, and in rather less than fifteen minutes a boy, a little less in size than the first, was born. The third, a girl of full size, followed (footling) in about twenty minutes. The placenta (which I regret was not preserved,) soon came away, in one mass, the uterine membranes being common to the whole; although, from the appearances presented, I doubt not that injection would have shown little, if any communication among the placental vessels of the three children. The mother has been able to nurse one of the children. The three are now alive and well.

In many systematic works, it is stated that plurality of children, in utero, cannot be positively ascertained previous to actual labour. In the present case, the mother had, for weeks previous, no doubt on the subject; and in another case, which I attended about six years ago, the mother, an intelligent individual, minutely described the separate movements of twin children, at least two months previous to the birth.—*London and Edin. Monthly Journal.*

FACTS RELATING TO THE PERIOD AT WHICH MENSTRUATION CEASES IN WOMAN, AND THE EFFECTS THEREBY PRODUCED ON THE HEALTH.

BY MM. DE MUYNCK AND KLUYSKENS.

It is a fact that much more attention has been directed to the period at which the catamenia appear, than to that at which they cease; one cause of which, probably, may be the greater number of females subject to the former of these phenomena, and their tender age, and the little importance, in the majority of cases attached to the latter. Too little attention, indeed, has probably been given to the cessation of the catamenia, and many states have been attributed to a morbid condition of the uterus, which were in reality nothing more than a prolongation of the normal state, and vice versa. The following facts may, perhaps, throw light on the subject.

Return of the menses at an advanced age, cure of some obstinate affections.

CASE 1. A nun, aged 62, of a sanguineous constitution, was seized with obstinate gastralgia, after the cessation of the menses at the age of 52. For nine years she was treated by many different medical men without relief. The following are the symptoms from which she suffered when I saw her. Palpitation, with pain at the epigastrium two or three hours after taking food; digestion slow and difficult; fetid eructations, constipation, no appetite, tongue clean, urine watery, pulse natural, character irritable, sleep good. Light tonic regimen, occasional application of leeches to the anus, keeping up the spirits (moral) of the patient. In the course of a short time her sufferings were alleviated, the constipation was less obstinate, and she experienced a feeling of comfort unknown for many years. The melioration continued up to the period when a sanguineous evacuation took place

from the uterus; it lasted four days, was unaccompanied with pain or any functional disturbance whatever, but there was considerable amendment in all the gastralgic phenomena. Another discharge occurred twenty-eight days after the first, and from that period the menses have recurred with their normal regularity, and now, though the lady is aged 73, they return with as great regularity as they did when she was at the age of 20. Since this re-appearance of the menses, not only have all the gastric symptoms disappeared, but she has continued to enjoy the most perfect health.

CASE 2. A nun, aged 90, had menstruated regularly from the age of 15 to 52; at this latter period she was seized with violent colic, which continued to recur at intervals for the space of two years. To this succeeded tic douloureux in well marked paroxysms; it resisted a variety of remedies, and ceased only at the age of 60, at which period the menses re-appeared without pain, and they have recurred regularly since every month; she enjoys excellent health, and is in full possession of all her faculties, moral and intellectual; she exhibits, besides, tastes and ideas which are generally confined to youth.

Examples of menstruation continuing to an advanced age, are not uncommon. Many authors mention females who have given birth to healthy children, at the advanced age of 67 and 70 (?) the two cases cited above are opposed to the opinion commonly entertained, that prolonged menstruation is generally met with in females addicted to sexual pleasures. The subjects of the two preceding cases were devoted to celibacy, and led a rigid and austere life.

Supplementary hemorrhage from the mamma at an advanced age, alternating with paroxysms of asthma, and terminating in a cancer of the breast.

CASE 3. M., of a sanguineous constitution, has had three children, and for 40 years enjoyed excellent health. At that age the menses becoming less abundant, she began to experience wandering pains in both extremities, with a feeling of oppression and fatigue. This state continued two years without exciting attention. At the end of that period, however, the symptoms increased, and she was seized with occasional attacks of asthma, which usually preceded the appearance of the menses; at each return of these the left breast became swollen, with an intolerable feeling of itchiness around the nipple, the other breast remained perfectly healthy; the swelling of the breast sensibly increased; the veins became prominent, and the nipple in a state of erythema, and surrounded with an areola of a violet red colour.

The menses now became more and more scanty, and the attacks of asthma, more frequent and intense, resisted all the means employed. At this time a small quantity of pale blood flowed from the enlarged mamma, it escaped in drops, and might weigh 20 or 30 grs., she was then 52, and the menses had entirely disappeared.

This slight hemorrhage completely relieved the asthmatic attacks, and the breast regained its natural size and color. From this period, a state of orgasm occurred periodically in the breast, similar to what is observed in the uterus previous to the appearance of the menses. The discharge of blood followed, and when this was scanty, the attacks of asthma recurred with great intensity.

She lived for five years and a half with this singular menstrual flux, but at that period a scirrhus tumour appeared in the breast, which soon passed into the state of cancer, under which she sunk, and died at the age of 58.—*Ib.*, from *Gazette Med.*, Sept. 1844.